STATEMENT OF SENATOR ARLEN SPECTER

Heath Care Reform

Mr. SPECTER. Mr. President, There is no doubt America is in need of major health care reform. With a reported 47 million people without health insurance, the status quo is not acceptable. Additionally, there are millions more Americans who are underinsured, with health insurance that is inadequate to cover their needs. Families are forced to make tough sacrifices in order to pay medical expenses or make the agonizing choice to go without health care coverage. There are far too many Americans whose financial and physical health is jeopardized by the rising costs of health care.

In the coming weeks and months Congress will consider health care reform which seeks to address the health care crisis, by addressing access to quality care, wellness programs and payment improvements. We need to agree on a balanced, common sense solution that reins in costs, protects the personal doctor patient relationship and shifts our focus to initiatives in preventive medicine and research.

I believe that ensuring all Americans have access to quality, affordable health care coverage is essential for the health and future of our nation. The creation of an insurance pooling system, such as the one established in Massachusetts in 2006, could serve as a model to provide health insurance to all individuals. The Massachusetts program created a connector which allowed individuals to group together to improve purchasing power to achieve affordable, quality coverage for the entire population and to equitably share risk. However, Congress must be

mindful of the cost of providing this care and reforms should not affect those who want to maintain their current insurance through their employer.

Health reform legislation should include health benefit standards that promote healthy lifestyles, wellness programs and provide preventive services and treatment needed by those with serious and chronic diseases. Health care coverage must be affordable with assistance to those who do not have the ability to pay for health care. While I am concerned about a requirement to obtain health insurance, I understand that without it, health providers are forced to write off expensive, uncompensated care that we all pay in the form of higher premiums.

In reforming health care we must work to ensure equity in health care access, treatment, and resources to all people and communities regardless of geography, race or pre-existing conditions. The effort to improve health care should improve care in underserved communities in both urban and rural areas.

The effect of these reforms on employers and providers must be kept in mind. Affordable and predictable health costs to businesses and employers and effective cost controls that promote quality, lower administrative costs and long term financial sustainability should be a part of these reforms. Payment reforms for physicians and other health providers should reflect the cost of providing health care so that there will be providers in the future.

This legislation will present an opportunity to address a number of other health related issues, including fraud and abuse in the health care industry, advanced directives, medical research and Medicare reforms. These ideas are an outline for health care reform legislation, which I believe can benefit all Americans. I am eager to discuss these ideas and look forward to hearing from constituents, colleagues and interested parties on all aspects of health care reform.

On March 5, 2009, at the request of President Obama, I participated in the White House Forum on Health Reform. During this forum, my colleagues from the Senate and House of Representatives and other health care interest representatives shared priorities and concerns for health care reform. This open process helped flush out ideas and develop a path for reform. Since that time, regional forums have been held throughout the country so more voices can be heard on this important issue and President Obama has worked closely with those representing all health care sectors to find common ground on reform. This effort was highlighted on May 12, 2009, by an agreement with executives of a number of groups, including the Service Employees International Union and PhRMA, to provide $2 trillion in health care savings.

While the White House Health Forum was a bipartisan event, I am concerned that the passage of health reform legislation could be lost to partisanship. The effort to bring about health reform can and should be a bipartisan effort. As a cosponsor of the Healthy Americans Act, introduced by Senators Wyden and Bennett and cosponsored by seven Democrats and four Republicans, I have firsthand experience with finding common ground on health care.

From the outset, the goal for passage of this legislation should be to have 80 Senators vote in support of it. Recently Sen. Grassley, after a lunch with President Obama, noted that "the White House prefers a bipartisan agreement." While some people have indicated they would prefer a bill passed by 51%, the White House's sentiments are encouraging. We have to try to get as broad a base as possible to get a bill passed.

The most talked about issue to date is that of a public plan or government operated program competing against private plans in the insurance market. A starting point for discussion on this issue could be the proposal made by Senator Schumer on May 4, 2009, which seeks to maintain a level playing field between the private sector and any public plan. The proposal holds that any public program should comply with all the rules and standards by which the private insurers must abide. The principles include that the public plan should:

- be self-sustaining through premiums and co-pays. Further, the public plan should not be subsidized by government funds and must maintain a reserve fund as private insurers do;
- not require healthcare providers to participate because they participate in Medicare and payments to providers must be higher than Medicare;
- be required to offer the same minimum benefits as private plans;
- be managed by different officials than those regulating the insurance market.

I recently spoke with Senator Enzi about this issue and he raised some concerns regarding fair competition between private and public plans. Specifically, he was concerned that there wouldn't be a level playing field as the government doesn't have to make a profit, where as private companies do. Further, if the public plan becomes insolvent will the government

intervene? I agree that competition lies at the heart of any successful market economy and these concerns and others need to be addressed as we discuss and consider a public plan option.

There are many variations in which a public plan could be brought forward, including offering it as a fallback if no private insurers are willing to provide coverage in a region. In Pennsylvania, a state administered insurance program for doctors and hospitals was established to provide access to medical malpractice insurance. This program could be phased out if the insurance commissioner certifies, pursuant to annual review, that sufficient private insurance capacity exists. These principals could be extended to a public plan offered to individuals. Whereby a public plan could be put into place subject to annual certification by the Secretary of Health and Human Services that a public plan is necessary to provide stable and affordable health insurance; if it isn't needed then the government plan shall be privatized or eliminated.

This issue will be hotly debated as health reform moves forward. As we begin, let me be clear that I am opposed to placing a giant bureaucracy between a doctor and patient regarding health decisions. Americans should be able to get treatment when they need it, and I will work to protect this right as we move forward. As I have stated, I am open to discussing the best method in which to cover all Americans, including considering a public plan option and look forward to examining all of the options with my colleagues as the legislation progresses.

Another issue that will be the focus of great debate will be the cost of the legislation. Until bill language is produced by the Finance and HELP Committees, it will be difficult to determine the cost of health reform. A recent estimate of this reform is $120 billion per year,

which is, by all standards, a large sum. However, the cost of inaction may be far greater. The United States spent approximately $2.2 trillion on health care in 2007, or $7,421 per person. This comes to 16.2% of Gross Domestic Product, nearly twice the average of other developed nations. Every effort to find cost saving proposals that can also bring improvements to health reform should be included in this legislation

**NIH/Cures Action Network**

The National Institutes of Health (NIH) is the crown jewel of the Federal Government and are responsible for enormous strides in combating the major ailments of our society including heart disease, diabetes, cancer, Alzheimer's, and Parkinson's diseases. I believe continued funding for the NIH and medical research should be another tenet of the health care debate. The NIH provides funding for biomedical research at our Nation's universities, hospitals, and research institutions. I along with Senator Harkin led the effort to double funding for the NIH from 1998 through 2003. When I became Chairman of the Labor, Health and Human Services and Education Appropriations Subcommittee in 1996, funding for the NIH was $12 billion; in fiscal year 2009 funding was increased to $30 billion.

Regrettably, federal funding for NIH has steadily declined from the $3.8 billion increase provided in 2003, when the 5-year doubling of NIH ended. To jumpstart the funding in NIH, I worked to include a provision in the American Recovery and Reinvestment Act to increase NIH funding by a total of $10 billion.

NIH research has provided tremendous benefits to many individuals with diseases. The following are examples of the cost of and success in reducing cancer deaths and cardiovascular disease.

CANCER: The NIH estimates overall costs of cancer in 2007 at $219.2 billion: $89 billion for direct medical costs; $18.2 billion for lost productivity due to illness; and $112 billion for lost of productivity due to premature death.

- Breast Cancer – Breast cancer death rates have steadily decreased in women since 1990. The 5-year relative survival for localized breast cancer has increased from 80% in the 1950s to 98% today. If the cancer has spread regionally, the current 5-year survival is 84%.

- Childhood Cancer – For all childhood cancers combined, 5-year relative survival has improved markedly over the past 30 years, from less than 50% before the 1970s to 80% today.

- Leukemia – Death rates have decreased by about 0.8% per year since 1995. For acute lymphocytic leukemia, the survival rate has increased from 42% in 1975-1977 to 65% in 1996-2003.

- Lymphoma – The five-year survival rates for Hodgkin's lymphoma has increased dramatically from 40% in 1960-1963 to more than 86% in 1996-2003. For non-Hodgkin

lymphoma, the survival rates have increase from 31% in 1960-1963 to 63.8% in 1996-2003.

- Prostate Cancer – Over the past 25 years, the 5-year survival rate has increased from 69% to almost 99%.

CARDIOVASCULAR DISEASE: According to the American Heart Association, the estimated direct and indirect cost of cardiovascular disease in the United States in 2008 was $448.5 billion.

- Coronary Artery Disease - Between 1994 and 2004, the number of deaths from Coronary Artery Disease declined by 18%.

- Stroke - Between 1995 and 2005, the number of stroke deaths declined 13.5 percent.

These are tremendous accomplishments and more must be done to build on our advancements. We ought to include the $10 billion in stimulus money in the NIH base funding level to see to it that the funding was not just a one-time shot. The $10 billion that was provided in the stimulus package for NIH was for a two year period; however, I feel that that $10 billion should be added to the $30 billion already appropriated in fiscal year 2009. I support a funding level of $40 billion for FY2010 which would require raising the appropriation by another $5 billion.

Scientists have approached me with stories of how NIH grant applications have skyrocketed since the NIH funding increase in the American Recovery and Reinvestment Act and that the boost has encouraged a new generation of scientists to dedicate themselves to medical research. The effort to increase NIH funding should also be matched by an effort to translate scientific discoveries in the laboratory to the patient's bedside. To meet this need, I introduced S.914, to establish the Cures Acceleration Network (CAN). This $2 billion Network would be a separate independent agency and would not take research dollars away from the NIH. The Network would make research awards to promising discoveries. The grant projects would also have a flexible expedited review process to get funds into the hands of scientists as quickly as possible. Drugs or devices that were funded by the CAN – would benefit from a streamlined FDA review to speed up the approval process for patient use. Implementing this legislation as part of health reform would enhance the important research of NIH by bridging the chasm between a basic scientific discovery and new health care treatments.

**ADVANCED DIRECTIVES**

The issue of end of life treatment is such a sensitive subject and no one should decide for anyone else what decision that person should make for end-of-life medical care. Advanced directives give an individual an opportunity to make the very personal decision as to the nature of care a person wants at the end of their life. That is, to repeat, a highly personalized judgment for the individual.

Advanced directives should be examined because of the great expense of end of life care. Statistics show that 27 percent of Medicare expenditures occur during a person's last year of life. Beyond the last year of life, a tremendous percentage of medical costs occur in the last month, weeks and days. It has been estimated that the use of advanced directives could save 6 percent of all Medicare spending or $24 billion in 2008.

Individuals should have access to information about advanced directives. As part of a public education program, I included an amendment to the Medicare Prescription Drug and Modernization Act of 2003, which directed the Secretary of Health and Human Services to include in its annual "Medicare and You" handbook, a section that specifies information on advanced directives, living wills, and durable powers of attorney. As the former Ranking Member and Chairman of the Labor, Health and Human Services, and Education Appropriations Subcommittee, I worked to ensure that this information continues to be published in the "Medicare and You" handbook.

There are many ways which have been discussed to improve the use of advanced directives. One approach could be to increase education for beneficiaries. It has also been suggested that filling out an advanced directive could be a requirement for joining Medicare. Another suggestion I received was to provide a discount on Medicare Part B premiums for those who fill out an advanced directive. While efforts to inform beneficiaries have improved, including a requirement that the issue be discussed at the beneficiaries' introductory Medicare exam, more must be done to increase usage of advanced directives. On this front, I am eager to

explore and analyze the range of possibilities while ensuring that individuals and their families' sensitivities surrounding the end of life care receive paramount priority.

**Healthy Lifestyles**

Some of the most prevalent diseases of today can be prevented by small changes in people's behavior. For example, 30 minutes of moderate physical activity each day, the equivalent of a brisk walk, can reduce the risk of a heart attack by up to 50%. Increasing one's fruit and vegetable consumption can reduce the risk of colon cancer by up to 50%. Obese and overweight individuals suffering metabolic syndrome and Type 2 diabetes showed health improvements after only three weeks of diet and moderate exercise. Health care reform should include policies that encourage people to make responsible decisions about their health and create environments to do so. The health benefits are real, achievable, measurable, and cost effective.

One way in which to encourage healthy behavior is through health education in schools, which is proven to reduce the prevalence of health risk behaviors among young people. For example, health education resulted in a 37% reduction in the onset of smoking among 7th graders. In addition, obese girls in the 6th and 8th grades lost weight through a health education program, and students who attended a school-based life-skills training program were less likely than other students to smoke or use alcohol or marijuana.

Funding community based health programs could also be a tenet of health reform. In July 2008, the Trust for America's Health stated that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within 5 years. This is a return of $5.60 for every $1 invested. Opportunities to save money on the cost of health care through education and proactive community based prevention programs should be included in health reform legislation.

**Healthcare Fraud and White Collar Crime**

Surveying recent caselaw reveals that individual criminals convicted of healthcare fraud can be sentenced to anywhere from 5 to 13 years in prison, substantial penalties and supervised release for a period of years. In any healthcare reform proposal, I believe we must address the significant potential for people of ill will and profit motives to defraud the government at the expense of the taxpayers. Therefore, I will push hard for enhanced sentences with real jail time for white collar fraudsters. As the Chairman of the Crime and Drug Judiciary Subcommittee, I will push for consideration of sentencing enhancements as at least one alternative and, where appropriate, lengthy jail sentences where the financial losses to the government are great. It would be intolerable for criminals to defraud the government of millions of dollars only to have to pay a fine that amounts to the cost of doing business.

According to the National Insurance Crime Bureau and the National Health Care Anti-Fraud Association, the annual loss from health fraud is 10 percent of the $2.2 trillion spent

annually on healthcare, or $220 billion. This amount of fraud must be identified and warrants real jail time, which should be taken up in this reform.

**Medicare Geographic Wage Index**

Health care reform provides an opportunity to correct a long standing problem in the Medicare payment system. In determining the payments to hospitals for services, Medicare takes into account the location of a hospital and how much those employees are paid. It is understandable that some areas of the country, where the cost of living is higher, should be reimbursed at higher levels. However, the current system has led to many imbalances that have left some areas of the country disadvantaged. In Pennsylvania, for example, the Scranton – Wilkes-Barre area and Allegheny Valley have received decreasing Medicare payments, which have forced a pay reduction to employees and a reduction in services to patients that rely on them.

Last year, the Medicare Payment Advisory Commission (MedPAC) released a report calling for the system to be reformed. The Commission stated that the current system created "cliffs" in payments, which resulted in arbitrary changes in payments in neighboring areas. These disparities can affect competition for employees and will harm services to Medicare beneficiaries. This legislation must include the reforms supported by MedPAC to correct this serious problem of inequity.

The health care crisis in our country endangers the health of our people, our economic viability and our future stability. Now, more so than ever before, it is critical that we pass legislation to ensure all Americans have access to quality and affordable health care. This undertaking requires prompt and effective action. I remain open to ideas on how to accomplish this exceptional task and look forward to working with my colleagues to determine the best path to do so.